

		FOR OHF USE				

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0041590</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>International Village</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/04</u> to <u>12/31/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>4815 South Western Ave.</u> <u>Chicago</u> <u>60609</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		(Signed) _____ (Date) _____	
Telephone Number: <u>(773) 927-4200</u> Fax # <u>(773) 927-8742</u>		(Type or Print Name) _____	
IDPA ID Number: <u>363928303001</u>		(Title) _____	
Date of Initial License for Current Owners: <u>09/11/00</u>		(Signed) _____ (Date) _____	
Type of Ownership:		(Print Name and Title) <u>Edward N. Slack, C.P.A.</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village# 0041590 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>218</u>	Skilled (SNF)	<u>218</u>	<u>79,788</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>218</u>	TOTALS	<u>218</u>	<u>79,788</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>55,435</u>	<u>3,084</u>	<u>7,844</u>	<u>66,363</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>55,435</u>	<u>3,084</u>	<u>7,844</u>	<u>66,363</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 83.17%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/AF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 9/11/00

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 9/11/00 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 218 and days of care provided 7,401Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	275,790	67,317	33,358	376,465		376,465	(5,129)	371,336			1
2	Food Purchase		254,683		254,683		254,683	2,487	257,170			2
3	Housekeeping	242,252	55,347	13,383	310,982		310,982	(6,372)	304,610			3
4	Laundry	28,270	38,853	8,250	75,373		75,373		75,373			4
5	Heat and Other Utilities			257,118	257,118		257,118	1,659	258,777			5
6	Maintenance	91,283	248	198,366	289,897		289,897	4,931	294,828			6
7	Other (specify):*							2,019	2,019			7
8	TOTAL General Services	637,595	416,448	510,475	1,564,518		1,564,518	(406)	1,564,112			8
	B. Health Care and Programs											
9	Medical Director			21,300	21,300		21,300		21,300			9
10	Nursing and Medical Records	2,688,393	150,137	395,678	3,234,208		3,234,208	1,764	3,235,972			10
10a	Therapy	76,549		10,499	87,048		87,048		87,048			10a
11	Activities	127,067	6,702	2,127	135,896		135,896		135,896			11
12	Social Services	166,817		7,571	174,388		174,388	11,930	186,318			12
13	Nurse Aide Training											13
14	Program Transportation			134	134		134		134			14
15	Other (specify):*							12,352	12,352			15
16	TOTAL Health Care and Programs	3,058,826	156,839	437,309	3,652,974		3,652,974	26,046	3,679,020			16
	C. General Administration											
17	Administrative	132,822		2,030	134,852		134,852	15,230	150,082			17
18	Directors Fees											18
19	Professional Services			395,176	395,176	(40,368)	354,808	(289,426)	65,382			19
20	Dues, Fees, Subscriptions & Promotions			78,662	78,662		78,662	(30,832)	47,830			20
21	Clerical & General Office Expenses	74,915	25,860	568,087	668,862		668,862	(319,169)	349,693			21
22	Employee Benefits & Payroll Taxes			676,042	676,042		676,042	(13,624)	662,418			22
23	Inservice Training & Education			57	57		57		57			23
24	Travel and Seminar			1,547	1,547		1,547	4,476	6,023			24
25	Other Admin. Staff Transportation			1,396	1,396		1,396		1,396			25
26	Insurance-Prop.Liab.Malpractice			207,344	207,344		207,344	962	208,306			26
27	Other (specify):*							28,093	28,093			27
28	TOTAL General Administration	207,737	25,860	1,930,341	2,163,938	(40,368)	2,123,570	(604,290)	1,519,280			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,904,158	599,147	2,878,125	7,381,430	(40,368)	7,341,062	(578,650)	6,762,412			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number International Village

#0041590

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			88,197	88,197		88,197	423,593	511,790			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			273,996	273,996		273,996	814,737	1,088,733			32
33	Real Estate Taxes			286,319	286,319	40,368	326,687	2,049	328,736			33
34	Rent-Facility & Grounds			1,155,036	1,155,036		1,155,036	(1,149,519)	5,517			34
35	Rent-Equipment & Vehicles			3,636	3,636		3,636	1,996	5,632			35
36	Other (specify):*			3,685	3,685		3,685	3,598	7,283			36
37	TOTAL Ownership			1,810,869	1,810,869	40,368	1,851,237	96,454	1,947,691			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	225,802	674,063	488,046	1,387,911		1,387,911	(82,438)	1,305,473			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			119,682	119,682		119,682		119,682			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	225,802	674,063	607,728	1,507,593		1,507,593	(82,438)	1,425,155			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,129,960	1,273,210	5,296,722	10,699,892		10,699,892	(564,634)	10,135,258			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(220,293)	30		9
10 Interest and Other Investment Income	(65)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(118)	02		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(480,362)	21		24
25 Fund Raising, Advertising and Promotional	(14,304)	20		25
26 Income Taxes and Illinois Personal				26
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(44,894)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (760,036)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	195,402		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 195,402		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (564,634)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
 (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.			\$		38
39					39
40 Gift and Coffee Shops					40
41 Barber and Beauty Shops					41
42 Laboratory and Radiology					42
43 Prescription Drugs					43
44 Exceptional Care Program					44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

International Village

00045500

Report Period Beginning: 01/01/04

Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	Theft Loss	\$ (380)	21 1
2	Collection Expense	(1,600)	21 2
3	Cable	(500)	6 3
4	Building Company - Filing Fees	(250)	21 4
5	Auto Fee	(5)	32 5
6	COPY Dues	(1,392)	20 6
7	Expense relating to another facility	(500)	21 7
8	Prior Year & Duplicated Legal Fees	(7,520)	19 8
9	Capitalized R&M	(2,265)	06 9
10	Related Party Interest	(24,800)	32 10
11	Accrued Legal Fee	(3,780)	19 11
12			12
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96			96
97			97
98			98
99			99
100			100
101	Total	(44,894)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(40)	435		(3,334)	(2,190)				(5,129)	1
2	Food Purchase	(118)							2,605				2,487	2
3	Housekeeping				(6,372)								(6,372)	3
4	Laundry													4
5	Heat and Other Utilities					1,659							1,659	5
6	Maintenance	(2,773)				1,771		5,908	25				4,931	6
7	Other (specify):*						236	1,444	339				2,019	7
8	TOTAL General Services	(2,891)			(6,412)	3,865	236	4,018	779				(406)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(18,883)			20,647					1,764	10
10a	Therapy													10a
11	Activities													11
12	Social Services							11,930					11,930	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*						7,586	4,766					12,352	15
16	TOTAL Health Care and Programs				(18,883)		7,586	37,343					26,046	16
	C. General Administration													
17	Administrative							15,065	165				15,230	17
18	Directors Fees													18
19	Professional Services	(3,748)				(285,695)			17				(289,426)	19
20	Fees, Subscriptions & Promotions	(15,696)				(15,145)			9				(30,832)	20
21	Clerical & General Office Expenses	(482,538)	250		98	16,178		146,544	299				(319,169)	21
22	Employee Benefits & Payroll Taxes			(433)	(408)		(12,783)						(13,624)	22
23	Inservice Training & Education													23
24	Travel and Seminar					4,402			74				4,476	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice					898			64				962	26
27	Other (specify):*						4,645	23,448					28,093	27
28	TOTAL General Administration	(501,982)	250	(433)	(310)	(279,362)	(8,138)	185,057	628				(604,290)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(504,873)	250	(433)	(25,605)	(275,497)	(316)	226,418	1,407				(578,650)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number International Village# 0041590

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(220,293)	597,802			16,445				29,639			423,593	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(34,870)	846,289						9	3,309			814,737	32
33	Real Estate Taxes					2,049							2,049	33
34	Rent-Facility & Grounds		(1,155,036)			5,172			345				(1,149,519)	34
35	Rent-Equipment & Vehicles					1,989			7				1,996	35
36	Other (specify):*		3,598										3,598	36
37	TOTAL Ownership	(255,163)	292,653			25,655			361	32,948			96,454	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(16,359)				(4,759)	(61,320)			(82,438)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers				(16,359)				(4,759)	(61,320)			(82,438)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(760,036)	292,903	(433)	(41,965)	(249,842)	(316)	226,418	(2,991)	(28,372)			(564,634)	45

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Highlander Care Center LLC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rent	\$ 1,155,036	Highlander Care Center LLC		\$	\$ (1,155,036) 1
2	V	21 Filing Fees		Highlander Care Center LLC		250	250 2
3	V	30 Depreciation		Highlander Care Center LLC		597,802	597,802 3
4	V	36 Amortization		Highlander Care Center LLC		3,598	3,598 4
5	V	32 Interest Expense		Highlander Care Center LLC		846,289	846,289 5
6	V						6
7	V						7
8	V						8
9	V						9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 1,155,036			\$ 1,447,939	\$ * 292,903 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 79,766	\$ 79,766	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	80,199	CCS EMPLOYEE BENEFIT GROUP	100.00%		(80,199)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 80,199			\$ 79,766	\$ * (433)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 DIETARY	\$ 271	XCEL MEDICAL SUPPLY, LLC	100.00%	\$ 231	\$ (40)	15
16	V	02 FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03 HOUSEKEEPING	42,951	XCEL MEDICAL SUPPLY, LLC	100.00%	36,579	(6,372)	17
18	V	04 LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06 REPAIRS & MAINTENANCE		XCEL MEDICAL SUPPLY, LLC	100.00%			19
20	V	10 NURSING	127,279	XCEL MEDICAL SUPPLY, LLC	100.00%	108,396	(18,883)	20
21	V	10A THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12 SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21 CLERICAL & GENERAL OFFICE	(663)	XCEL MEDICAL SUPPLY, LLC	100.00%	(565)	98	23
24	V	22 EMPLOYEE BENEFITS	2,752	XCEL MEDICAL SUPPLY, LLC	100.00%	2,343	(408)	24
25	V	39 ANCILLARY	110,267	XCEL MEDICAL SUPPLY, LLC	100.00%	93,908	(16,359)	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 282,857			\$ 240,892	\$ * (41,965)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary	\$	Care Centers, Inc.	100.00%	\$ 435	\$ 435	15
16	V	05 Utilities		Care Centers, Inc.	100.00%	1,659	1,659	16
17	V	06 Maintenance		Care Centers, Inc.	100.00%	1,771	1,771	17
18	V	10 Nursing		Care Centers, Inc.	100.00%			18
19	V	11 Activities		Care Centers, Inc.	100.00%			19
20	V	19 Professional Fees	294,625	Care Centers, Inc.	100.00%	8,930	(285,695)	20
21	V	20 Dues and Subscriptions	18,235	Care Centers, Inc.	100.00%	3,090	(15,145)	21
22	V	21 Office & Clerical		Care Centers, Inc.	100.00%	16,178	16,178	22
23	V	24 Travel and Seminar		Care Centers, Inc.	100.00%	4,402	4,402	23
24	V	26 Insurance		Care Centers, Inc.	100.00%	898	898	24
25	V	30 Depreciation		Care Centers, Inc.	100.00%	16,445	16,445	25
26	V	32 Interest		Care Centers, Inc.	100.00%			26
27	V	33 Real Estate Taxes		Care Centers, Inc.	100.00%	2,049	2,049	27
28	V	34 Rent - Building		Care Centers, Inc.	100.00%	5,172	5,172	28
29	V	35 Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,989	1,989	29
30	V	25 Bus Reimbursement		Care Centers, Inc.	100.00%			30
31	V	02 Food		Care Centers, Inc.	100.00%			31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 312,860			\$ 63,018	\$ * (249,842)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06 Maintenance Salary	\$ 1,611	Care Centers, Inc.	100.00%	\$ 1,611	\$	15
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	236	236	16
17	V	10 Nursing Salary	35,014	Care Centers, Inc.	100.00%	35,014		17
18	V	10a Rehab Salary	10,499	Care Centers, Inc.	100.00%	10,499		18
19	V	11 Activity Salary		Care Centers, Inc.	100.00%			19
20	V	12 Social Service Salary	6,343	Care Centers, Inc.	100.00%	6,343		20
21	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	7,586	7,586	21
22	V	17 Administration Salary	2,030	Care Centers, Inc.	100.00%	2,030		22
23	V	21 Office Salary	29,723	Care Centers, Inc.	100.00%	29,723		23
24	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	4,645	4,645	24
25	V	22 Employee Benefits	12,783	Care Centers, Inc.	100.00%		(12,783)	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 98,003			\$ 97,687	\$ * (316)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary Salary	\$ 7,294	Care Centers, Inc.	100.00%	\$ 3,960	\$ (3,334)	15
16	V	03 Housekeeping Salary		Care Centers, Inc.	100.00%			16
17	V	06 Maintenance Salary		Care Centers, Inc.	100.00%	5,908	5,908	17
18	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,444	1,444	18
19	V	10 Nursing Salary		Care Centers, Inc.	100.00%	20,647	20,647	19
20	V	10a Rehab Salary		Care Centers, Inc.	100.00%			20
21	V	12 Social Services Salary		Care Centers, Inc.	100.00%	11,930	11,930	21
22	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	4,766	4,766	22
23	V	17 Administration Salary		Care Centers, Inc.	100.00%	15,065	15,065	23
24	V	21 Office Salary		Care Centers, Inc.	100.00%	146,544	146,544	24
25	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	23,448	23,448	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 7,294			\$ 233,712	\$ * 226,418	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary	\$ 5,147	Care Centers, Inc. - Health Systems Division	100.00%	\$ 642	\$ (4,505)	15
16	V	02 Food		Care Centers, Inc. - Health Systems Division	100.00%	2,605	2,605	16
17	V	06 Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	25	25	17
18	V	17 Administration		Care Centers, Inc. - Health Systems Division	100.00%	165	165	18
19	V	19 Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	17	17	19
20	V	20 Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	9	9	20
21	V	21 Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	299	299	21
22	V	24 Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	74	74	22
23	V	26 Insurance		Care Centers, Inc. - Health Systems Division	100.00%	64	64	23
24	V	32 Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	9	9	24
25	V	34 Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	345	345	25
26	V	35 Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	7	7	26
27	V	39 Ancillary Enteral Supplies	9,637	Care Centers, Inc. - Health Systems Division	100.00%	4,878	(4,759)	27
28	V	01 Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	2,315	2,315	28
29	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	339	339	29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 14,784			\$ 11,793	\$ * (2,991)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30 Depreciation	\$	Vent Lease, LLC.	100.00%	\$ 29,639	\$ 29,639	15
16	V	32 Interest		Vent Lease, LLC.	100.00%	3,309	3,309	16
17	V	39 Vent Reimbursement	61,320	Vent Lease, LLC.	100.00%		(61,320)	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 61,320			\$ 32,948	\$ * (28,372)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

0041590

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Adam Vales	Owner	Clerical	2.29%	See Attached	0.52	1.30%	Alloc Salary	\$ 538	22-7	1
2	Mark Steinberg	Relative	Administrative		See Attached	4.00	7.27%	Alloc Salary	2,702	17-7	2
3	Eric Rothner	Relative	Administrative		See Attached	1.40	3.03%				3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,240		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village# 0041590 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (____) _____

Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village# 0041590

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 2201 MAIN STREET
 City / State / Zip Code EVANSTON, IL 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 79,766	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 79,766	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village# 0041590

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization XCEL MEDICAL SUPPLY, LLCStreet Address 2201 MAIN STREETCity / State / Zip Code EVANSTON, IL 60202Phone Number (847)328-7600Fax Number (847)328-7615

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation		\$	\$		\$ 231	1
2	02	FOOD	Direct Allocation						2
3	03	HOUSEKEEPING	Direct Allocation					36,579	3
4	04	LAUNDRY	Direct Allocation						4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						5
6	10	NURSING	Direct Allocation					108,396	6
7	10A	THERAPY	Direct Allocation						7
8	12	SOCIAL SERVICE	Direct Allocation						8
9	21	CLERICAL & GENERAL OFFICE	Direct Allocation					(565)	9
10	22	EMPLOYEE BENEFITS	Direct Allocation					2,343	10
11	39	ANCILLARY	Direct Allocation					93,908	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 240,892	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village# 0041590Report Period Beginning: 01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Care Centers, Inc.

Street Address

2201 West Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905-3000

Fax Number

(847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01 Dietary	Patient Days	1,484,397	42	\$ 9,730	\$	66,363	\$ 435	1
2	05 Utilities	Patient Days	1,484,397	42	37,103		66,363	1,659	2
3	06 Maintenance	Patient Days	1,484,397	42	39,622		66,363	1,771	3
4	10 Nursing	Patient Days	1,484,397	42			66,363		4
5	11 Activities	Patient Days	1,484,397	42			66,363		5
6	19 Professional Fees	Patient Days	1,484,397	42	199,755		66,363	8,930	6
7	20 Dues and Subscriptions	Patient Days	1,484,397	42	69,116		66,363	3,090	7
8	21 Office & Clerical	Patient Days	1,484,397	42	361,868		66,363	16,178	8
9	24 Travel and Seminar	Patient Days	1,484,397	42	98,454		66,363	4,402	9
10	26 Insurance	Patient Days	1,484,397	42	20,081		66,363	898	10
11	30 Depreciation	Patient Days	1,484,397	42	367,842		66,363	16,445	11
12	32 Interest	Patient Days	1,484,397	42			66,363		12
13	33 Real Estate Taxes	Patient Days	1,484,397	42	45,838		66,363	2,049	13
14	34 Rent - Building	Patient Days	1,484,397	42	115,677		66,363	5,172	14
15	35 Rent - Equipment & Auto	Patient Days	1,484,397	42	44,486		66,363	1,989	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,409,572	\$		\$ 63,018	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village# 0041590 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06 Maintenance Salary	Direct Cost			264,919	264,919		1,611	1
2	07 Emp. Ben. - Gen. Serv.	Direct Cost			38,757			236	2
3	10 Nursing Salary	Direct Cost			209,584	209,584		35,014	3
4	10a Rehab Salary	Direct Cost			66,982	66,982		10,499	4
5	11 Activity Salary	Direct Cost							5
6	12 Social Service Salary	Direct Cost			66,710	66,710		6,343	6
7	15 Emp. Ben. - Healthcare	Direct Cost			50,220			7,586	7
8	17 Administration Salary	Direct Cost			38,431	38,431		2,030	8
9	21 Office Salary	Direct Cost			525,935	525,935		29,723	9
10	27 Emp. Ben. - Gen. Admin.	Direct Cost			82,566			4,645	10
11	22 Employee Benefits								11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,344,103	\$ 1,172,560		\$ 97,687	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village# 0041590

Report Period Beginning:

01/01/04

Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Care Centers, Inc.

Street Address

2201 West Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905-3000

Fax Number

(847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,484,397	42	88,579	66,363	3,960	1
2	03	Housekeeping Salary	Patient Days	1,484,397	42		66,363		2
3	06	Maintenance Salary	Patient Days	1,484,397	42	132,146	66,363	5,908	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,484,397	42	32,292	66,363	1,444	4
5	10	Nursing Salary	Patient Days	1,484,397	42	461,827	66,363	20,647	5
6	10a	Rehab Salary	Patient Days	1,484,397	42		66,363		6
7	12	Social Services Salary	Patient Days	1,484,397	42	266,840	66,363	11,930	7
8	15	Emp. Ben. - Healthcare	Patient Days	1,484,397	42	106,602	66,363	4,766	8
9	17	Administration Salary	Patient Days	1,484,397	42	336,976	66,363	15,065	9
10	21	Office Salary	Patient Days	1,484,397	42	3,277,864	66,363	146,544	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,484,397	42	524,485	66,363	23,448	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,227,610	\$ 4,564,232		\$ 233,712	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village# 0041590

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Care Centers, Inc.

Street Address

2201 West Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905-3000

Fax Number

(847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,144,835	93,149		14,784	642	1
2	02	Food	Billable Income	2,144,835	987,169		14,784	2,605	2
3	06	Maintenance	Billable Income	2,144,835	3,597		14,784	25	3
4	17	Administration	Billable Income	2,144,835	24,000		14,784	165	4
5	19	Professional Fees	Billable Income	2,144,835	2,500		14,784	17	5
6	20	Dues & Subscriptions	Billable Income	2,144,835	1,342		14,784	9	6
7	21	Office & Clerical	Billable Income	2,144,835	43,384		14,784	299	7
8	24	Travel & Seminar	Billable Income	2,144,835	10,755		14,784	74	8
9	26	Insurance	Billable Income	2,144,835	9,262		14,784	64	9
10	32	Interest Expense	Billable Income	2,144,835	1,371		14,784	9	10
11	34	Rent - Building	Billable Income	2,144,835	50,000		14,784	345	11
12	35	Rent - Equipment & Auto	Billable Income	2,144,835	1,080		14,784	7	12
13	39	Ancillary Enteral Supplies	Billable Income	2,144,835	98,519		14,784	4,878	13
14	01	Dietary - Salary	Billable Income	2,144,835	335,801	335,801	14,784	2,315	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	2,144,835	49,127		14,784	339	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,711,055	\$ 335,801		\$ 11,793	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village# 0041590

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Vent Lease, LLC

Street Address

2201 Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 674-1180

Fax Number

(847) 673-7741

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30 Depreciation	Direct Billing	620,670	29	\$ 300,000	\$	61,320	\$ 29,639	1
2	32 Interest	Direct Billing	620,670	29	33,493		61,320	3,309	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 333,493	\$		\$ 32,948	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village# 0041590 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (____) _____

Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village# 0041590 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (____) _____

Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village# 0041590

Report Period Beginning:

01/01/04

Ending:

12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	Corus Bank		X	Construction Loan			\$	8,889,109			\$	818,823	1						
2	Corus Bank		X	Second Mortgage				300,000				27,466	2						
3													3						
4													4						
5	See Supplemental Schedule												5						
	Working Capital																		
6	Diawa		X	Line of Credit				3,965,150				239,191	6						
7	Shareholder Loan	X		Working Capital				600,000				34,800	7						
8	See Supplemental Schedule											(31,482)	8						
9	TOTAL Facility Related							\$	13,754,259					\$	1,088,798	9			
	B. Non-Facility Related*																		
10	Interest Income											(65)	10						
11													11						
12													12						
13	See Supplemental Schedule												13						
14	TOTAL Non-Facility Related							\$						\$	(65)	14			
15	TOTALS (line 9+line14)							\$	13,754,259					\$	1,088,733	15			

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # * Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number International Village# 0041590

Report Period Beginning:

01/01/04

Ending:

12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8	Adjust Shareholder Interest	X					\$	\$			\$ (34,800)	8	
9	Allocated from Care Centers		X								9	9	
10	Allocated from Vent Lease		X								3,309	10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital										(31,482)	14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **International Village**# **0041590**Report Period Beginning: **01/01/04**

Ending:

12/31/04**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																																				
1. Real Estate Tax accrual used on 2003 report.		\$ 320,112	1																																	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 297,871	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ (22,241)	3																																	
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 310,609	4																																	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$ 40,368	5																																	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																																	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 328,736	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1999</td><td></td><td>8</td></tr> <tr><td>2000</td><td>5,865</td><td>9</td></tr> <tr><td>2001</td><td>357,200</td><td>10</td></tr> <tr><td>2002</td><td>304,867</td><td>11</td></tr> <tr><td>2003</td><td>295,822</td><td>12</td></tr> </table>	1999		8	2000	5,865	9	2001	357,200	10	2002	304,867	11	2003	295,822	12	<table border="1"> <tr><td colspan="2">FOR OHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2003</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2003	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
1999		8																																		
2000	5,865	9																																		
2001	357,200	10																																		
2002	304,867	11																																		
2003	295,822	12																																		
FOR OHF USE ONLY																																				
13	FROM R. E. TAX STATEMENT FOR 2003	\$	13																																	
14	PLUS APPEAL COST FROM LINE 5	\$	14																																	
15	LESS REFUND FROM LINE 6	\$	15																																	
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																	
2004 accrual = 2003 tax \$295,822 x 1.05 = \$310,609																																				
Allocated from Care Centers \$2049																																				

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME International Village COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041590

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200:

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>20-07-104-001-0000</u>	<u>Long Term Care Property</u>	\$ <u>214,549.23</u>	\$ <u>214,549.23</u>
2. <u>20-07-104-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>882.48</u>	\$ <u>882.48</u>
3. <u>20-07-104-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>759.99</u>	\$ <u>759.99</u>
4. <u>20-07-104-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>270.44</u>	\$ <u>270.44</u>
5. <u>20-07-104-009-0000</u>	<u>Long Term Care Property</u>	\$ <u>71,135.34</u>	\$ <u>71,135.34</u>
6. <u>20-07-104-011-0000</u>	<u>Long Term Care Property</u>	\$ <u>7,343.21</u>	\$ <u>7,343.21</u>
7. <u>20-07-104-012-0000</u>	<u>Long Term Care Property</u>	\$ <u>881.59</u>	\$ <u>881.59</u>
8. <u>See attached</u>	<u>Home Office Allocation</u>	\$ <u>106,873.39</u>	\$ <u>2,049.00</u>
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>402,695.67</u></u>	\$ <u><u>297,871.28</u></u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME International Village COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041590

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:

89,132

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

3

C. Does the Operating Entity?

☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☐ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	115,710	1995	\$ 901,533	1
2	Alloc Care Centers			15,723	2
3	TOTALS	115,710		\$ 917,256	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various	2000		169,034		20	8,450	8,450	31,983
10							-		-
11							-		-
12							-		-
13							-		-
14							-		-
15							-		-
16							-		-
17							-		-
18							-		-
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26							-		-
27							-		-
28							-		-
29							-		-
30							-		-
31							-		-
32							-		-
33							-		-
34							-		-
35							-		-
36							-		-

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	2 Year Constructed	3 Cost	4 Current Book Depreciation	5 Life in Years	6 Straight Line Depreciation	7 Adjustments	8 Accumulated Depreciation	9
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		12,627,413	332,446		360,783	28,337	1,533,328	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		60,661	2,492		2,492		5,173	68
69	Financial Statement Depreciation			39,934			(39,934)		69
70	TOTAL (lines 4 thru 69)		\$ 12,857,108	\$ 374,872		\$ 371,725	\$ (3,147)	\$ 1,570,484	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 12,857,108	\$ 374,872		\$ 371,725	\$ (3,147)	\$ 1,570,484	1
2	Storage Systems	2001	7,961		20	398	398	1,592	2
3	Telephone Wiring	2001	562		20	28	28	112	3
4	Cctv	2001	1,196		20	60	60	239	4
5	Cctv	2001	641		20	32	32	128	5
6	Drapery	2001	2,324		20	116	116	455	6
7	Cubicle Curtains	2001	1,632		20	82	82	320	7
8	Telephone Wiring	2001	419		20	21	21	81	8
9	Telephone Wiring	2001	555		20	28	28	106	9
10	Telephone Wiring	2001	419		20	21	21	81	10
11	Surge Suppressor	2001	860		20	43	43	165	11
12	Telephone Wiring	2001	592		20	30	30	112	12
13	Telephone Wiring	2001	681		20	34	34	128	13
14	Telephone Wiring	2001	617		20	31	31	116	14
15	Telephone Wiring	2001	690		20	35	35	133	15
16	Telephone Wiring	2001	296		20	15	15	54	16
17	Telephone Wiring	2001	691		20	35	35	127	17
18	Telephone Wiring	2001	617		20	31	31	114	18
19	Satellite	2001	1,454		20	73	73	267	19
20	Telephone Wiring	2001	839		20	42	42	151	20
21	Telephone Wiring	2001	518		20	26	26	93	21
22	Telephone Wiring	2001	395		20	20	20	71	22
23	Telephone Wiring	2001	321		20	16	16	57	23
24	Telephone Wiring	2001	358		20	18	18	65	24
25	Iron Fence	2001	3,800		20	190	190	665	25
26	Telephone Wiring	2001	1,911		20	96	96	335	26
27	Telephone Wiring	2001	1,036		20	52	52	177	27
28	Plumbing	2001	5,169		20	258	258	861	28
29	Sprinkler System Rep	2001	518		20	26	26	87	29
30	Hvac	2001	625		20	31	31	104	30
31	Telephone Wiring	2001	913		20	46	46	149	31
32	Anti-Freeze Sprinkle	2001	1,320		20	66	66	215	32
33	Clearing Lot	2001	4,847		20	242	242	788	33
34	TOTAL (lines 1 thru 33)		\$ 12,901,885	\$ 374,872		\$ 373,967	\$ (905)	\$ 1,578,632	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

STATE OF ILLINOIS

Page 12C

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 12,901,885	\$ 374,872		\$ 373,967	\$ (905)	\$ 1,578,632	1
2	Telephone Wiring	2001	863		20	43	43	140	2
3	Landscaping	2001	3,452		20	173	173	619	3
4	Code Alert	2001	693		20	35	35	113	4
5	Hvac	2001	875		20	44	44	142	5
6	Telephones	2002	804		20	80	80	241	6
7	Light Timmer & Control Board	2002	1,101		20	110	110	330	7
8	Phone Wiring	2002	518		20	52	52	155	8
9	Phone Wiring	2002	1,133		20	113	113	340	9
10	Boiler Work-Varius Invoices	2002	8,330		20	833	833	2,430	10
11	Telephone Work	2002	592		20	59	59	173	11
12	Telephone Work	2002	2,300		20	230	230	652	12
13	Check & Adjust System	2002	701		20	70	70	187	13
14	Telephones	2002	2,111		20	211	211	545	14
15	Roof Repairs	2002	1,246		20	125	125	322	15
16	Repair Elevator Door-3Rd Floor-Fire Damage	2002	3,201		20	640	640	1,601	16
17	Rehang Elevator Doors	2002	1,080		20	216	216	540	17
18	Repair Bathroom Showers	2002	1,858		20	186	186	449	18
19	Elevator Repair	2002	755		20	38	38	88	19
20	A/C Chiller Repair	2002	7,380		20	369	369	830	20
21	6' Chain Link Fence	2003	2,295		20	115	115	230	21
22	Carpet Cleaning	2003	1,072		20	107	107	205	22
23	Corner Guards	2003	1,031		20	52	52	99	23
24	Electrical Work	2003	5,250		20	525	525	963	24
25	Electrical Work	2003	5,540		20	554	554	1,016	25
26	6' Double Swing Gate	2003	1,098		20	110	110	201	26
27	Electrical Work	2003	2,390		20	239	239	418	27
28	Shower Equip & Repairs	2003	1,858		20	93	93	155	28
29	Wiring Repair	2003	556		20	56	56	83	29
30	Ceiling Mounts	2003	1,127		20	56	56	80	30
31	Humidity-Heat System	2003	500		20	50	50	67	31
32	Installment On Heat System	2003	500		20	50	50	63	32
33	Installment On Heat System	2003	500		20	50	50	58	33
34	TOTAL (lines 1 thru 33)		\$ 12,964,595	\$ 374,872		\$ 379,651	\$ 4,779	\$ 1,592,167	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 12,964,595	\$ 374,872		\$ 379,651	\$ 4,779	\$ 1,592,167	1
2	Installment On Heat System	2003	548		20	55	55	64	2
3	Repair Broken Main Line	2004	1,550		20	26	26	26	3
4	Tile & Carpeting Work	2004	2,502		20	42	42	42	4
5	Tile For 2Nd Fl	2004	2,014		20	34	34	34	5
6	Replace Tempering Valve	2004	657		20	5	5	5	6
7	Tel System Repair	2004	584		20	117	117	117	7
8	Electric Door Opener	2004	5,223		20	609	609	609	8
9	Roof Exhauster	2004	1,392		20	116	116	116	9
10	Door Keypad - Timer	2004	2,245		20	150	150	150	10
11	Frozen Pipes Repair	2004	682		20	68	68	68	11
12	Roof Work	2004	3,200		20	53	53	53	12
13	Relocating Water Pumps	2004	580		20	48	48	48	13
14	Repair Elevator	2004	1,559		20	117	117	117	14
15	New Sidewalk	2004	1,450		20	48	48	48	15
16	Reconstruct Elevator	2004	13,100		20	437	437	437	16
17	Door Alarms	2004	570		20	10	10	10	17
18	Showers - Posigrip	2004	825		20	14	14	14	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,003,276	\$ 374,872		\$ 381,600	\$ 6,728	\$ 1,594,125	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 13,003,276	\$ 374,872		\$ 381,600	\$ 6,728	\$ 1,594,125	1
2									2
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4									4
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,003,276	\$ 374,872		\$ 381,600	\$ 6,728	\$ 1,594,125	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 13,003,276	\$ 374,872		\$ 381,600	\$ 6,728	\$ 1,594,125	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,003,276	\$ 374,872		\$ 381,600	\$ 6,728	\$ 1,594,125	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 13,003,276	\$ 374,872		\$ 381,600	\$ 6,728	\$ 1,594,125	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,003,276	\$ 374,872		\$ 381,600	\$ 6,728	\$ 1,594,125	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 13,003,276	\$ 374,872		\$ 381,600	\$ 6,728	\$ 1,594,125	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,003,276	\$ 374,872		\$ 381,600	\$ 6,728	\$ 1,594,125	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 13,003,276	\$ 374,872		\$ 381,600	\$ 6,728	\$ 1,594,125	1
2									2
3									3
4									4
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6									6
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,003,276	\$ 374,872		\$ 381,600	\$ 6,728	\$ 1,594,125	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 13,003,276	\$ 374,872		\$ 381,600	\$ 6,728	\$ 1,594,125	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,003,276	\$ 374,872		\$ 381,600	\$ 6,728	\$ 1,594,125	34

**Improvement type must be detailed in order for the cost report to be considered complete

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 13,003,276	\$ 374,872		\$ 381,600	\$ 6,728	\$ 1,594,125	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,003,276	\$ 374,872		\$ 381,600	\$ 6,728	\$ 1,594,125	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)										
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar										
	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation
4	218		2000	2000	\$ 12,627,413	\$ 332,446	35	\$ 360,783	\$ 28,337	\$ 1,533,328
5										
6										
7										
8										
9	Improvement Type**									
10										
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**Improvement type must be detailed in order for the cost report to be considered complete

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
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45									45
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63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 12,627,413	\$ 332,446		\$ 360,783	\$ 28,337	\$ 1,533,328	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number International Village

0041590

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation	
4	2201 Main LLC			2002	\$ 21,668	\$ 542	40	\$ 542		\$ 1,354	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - 2201 Main LLC			2002	17,899	895	20	895		2,237	9
10	Allocation - 2201 Main LLC			2003	21,094	1,055	20	1,055		1,582	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 60,661	\$ 2,492		\$ 2,492	\$	\$ 5,173	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,159,505	\$ 336,933	\$ 115,914	\$ (221,019)	10	\$ 520,525	71
72	Current Year Purchases	143,205	17,988	11,986	(6,002)	10	11,986	72
73	Fully Depreciated Assets	19,726				10	19,726	73
74								74
75	TOTALS	\$ 1,322,436	\$ 354,921	\$ 127,900	\$ (227,021)		\$ 552,237	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocation from Care Centers			\$ 31,003	\$ 2,291	\$ 2,291		5	\$ 25,786	76
77										77
78										78
79										79
80	TOTALS			\$ 31,003	\$ 2,291	\$ 2,291			\$ 25,786	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 15,273,971	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 732,084	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 511,791	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (220,293)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,172,148	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocation from Care Centers				5,517			5
6								6
7	TOTAL				\$ 5,517			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 5,632 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$

13. /2006 \$

14. /2007 \$

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building,
please provide complete details on attached
schedule.

** This amount plus any amortization of lease
expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p style="text-align: right;"> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO </p> <p style="font-size: small;">If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 133,119	\$		\$ 133,119	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			58,364			58,364	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			158,447			158,447	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				256,107		256,107	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental			225,802		138,116	417,956		781,874	13
14	TOTAL			\$ 225,802		\$ 488,046	\$ 674,063		\$ 1,387,911	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number International Village

0041590

Report Period Beginning: 01/01/04

Ending:

12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/04

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 7,037	\$ 26,190	1
2	Cash-Patient Deposits	46,753	46,753	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,052,760	3,052,760	3
4	Supply Inventory (priced at)		9,065	4
5	Short-Term Investments			5
6	Prepaid Insurance	155,507	155,507	6
7	Other Prepaid Expenses	32,380	32,380	7
8	Accounts Receivable (owners or related parties)	701,859		8
9	Other(specify): See Attached Schedule	87,893	120,593	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,084,189	\$ 3,443,248	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,156,831	13
14	Buildings, at Historical Cost		9,618,909	14
15	Leasehold Improvements, at Historical Cost	280,712	1,518,915	15
16	Equipment, at Historical Cost	432,970	2,746,630	16
17	Accumulated Depreciation (book methods)	(334,583)	(4,031,971)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		110,568	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 379,099	\$ 11,119,882	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,463,288	\$ 14,563,130	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,462,314	\$ 1,462,314	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,461	44,461	28
29	Short-Term Notes Payable	3,965,150	3,965,150	29
30	Accrued Salaries Payable	112,867	112,867	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,541	6,541	31
32	Accrued Real Estate Taxes(Sch.IX-B)	310,609	310,609	32
33	Accrued Interest Payable	179,406	244,799	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	7,123	3,858,544	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,088,471	\$ 10,005,285	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	600,000	600,000	39
40	Mortgage Payable		9,189,109	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 600,000	\$ 9,789,109	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,688,471	\$ 19,794,394	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,225,183)	\$ (5,231,264)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,463,288	\$ 14,563,130	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,105,215)	1
2	Restatements (describe):		2
3	See Attached	(48,270)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,153,485)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,071,698)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,071,698)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,225,183)	24

*

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number International Village

0041590

Report Period Beginning: 01/01/04

Ending:

12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,377,109	1
2	Discounts and Allowances for all Levels	(1,885,888)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,491,221	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,554,063	6
7	Oxygen	55,474	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,609,537	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	275,250	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	62,433	19
20	Radiology and X-Ray	3,220	20
21	Other Medical Services	186,468	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 527,371	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	65	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 65	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,628,194	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	1,564,518	31
32	Health Care	3,652,974	32
33	General Administration	2,163,938	33
B. Capital Expense			
34	Ownership	1,810,869	34
C. Ancillary Expense			
35	Special Cost Centers	1,387,911	35
36	Provider Participation Fee	119,682	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,699,892	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,071,698)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,071,698)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number International Village

0041590

Report Period Beginning: 01/01/04

Ending:

12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,011	2,608	\$ 78,003	\$ 29.91	1
2	Assistant Director of Nursing	3,645	3,955	102,446	25.90	2
3	Registered Nurses	9,272	10,455	240,469	23.00	3
4	Licensed Practical Nurses	46,510	50,575	1,077,662	21.31	4
5	Nurse Aides & Orderlies	115,856	124,309	1,133,009	9.11	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	9,673	10,564	225,802	21.37	7
8	Rehab/Therapy Aides	4,907	5,303	76,549	14.44	8
9	Activity Director	1,638	2,218	30,901	13.93	9
10	Activity Assistants	12,399	13,246	96,166	7.26	10
11	Social Service Workers	11,554	13,007	166,817	12.83	11
12	Dietician					12
13	Food Service Supervisor	4,133	4,774	66,297	13.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,583	27,404	209,493	7.64	15
16	Dishwashers					16
17	Maintenance Workers	4,943	5,394	91,283	16.92	17
18	Housekeepers	31,432	33,136	242,252	7.31	18
19	Laundry	3,548	3,773	28,270	7.49	19
20	Administrator	1,859	2,187	76,224	34.85	20
21	Assistant Administrator	2,583	2,768	56,598	20.45	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,952	7,663	74,915	9.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,262	4,629	55,967	12.09	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	71	71	837	11.79	33
34	TOTAL (lines 1 - 33)	302,831	328,039	\$ 4,129,960 *	\$ 12.59	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	614	\$ 26,064	01-03	35
36	Medical Director	monthly	21,300	09-03	36
37	Medical Records Consultant	145	4,937	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	5,352	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,127	11-03	44
45	Social Service Consultant	22	1,228	12-03	45
46	Other(specify)				46
47					47
48	CCI - see attached		59,150	various	48
49	TOTAL (lines 35 - 48)	825	\$ 120,158		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,324	\$ 117,993	10-03	50
51	Licensed Practical Nurses	6,513	231,398	10-03	51
52	Nurse Aides	12	984	10-03	52
53	TOTAL (lines 50 - 52)	8,849	\$ 350,375		53

SEE ACCOUNTANTS' COMPILATION REPORT

[illegible]

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount				
Kristen Mitchell	Administrator	0	\$ 21,276	Workers' Compensation Insurance	\$ 98,249	IDPH License Fee	\$ 4,240				
Frank J. Santore	Administrator	0	35,205	Unemployment Compensation Insurance	68,109	Advertising; Employee Recruitment	29,568				
Gilberto Torres	Administrator	0	19,743	FICA Taxes	312,153	Health Care Worker Background Check (Indicate # of checks performed <u>80</u>)	1,610				
Jaime Roberts	Asst. Admin.	0	19,323	Employee Health Insurance	154,470	Dues & Subscriptions	5,519				
Jason Gold	Asst. Admin.	0	37,275	Employee Meals		Licenses & Fees	3,794				
				Illinois Municipal Retirement Fund (IMRF)*		Advertising & Promotion	32,540				
				Chicago Employer Tax	8,865	Allocated from Care Centers	3,099				
				Employee Physicals	1,705						
				Pension Expense	13,703						
				Union Dues	837						
				Other Employee Welfare	1,843	Less: Public Relations Expense	(
				Holiday Expense	2,483	Non-allowable advertising	(32,540)				
						Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 132,822			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 47,830				
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				\$ 662,417			
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees							
Administrative payroll allocated from Care Center			\$ 2,030	Description	Line #	Amount					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 2,030	G. Schedule of Travel and Seminar**							
C. Professional Services				Description							
Vendor/Payee	Type		Amount	Amount							
Frost Ruttenberg & Rothblatt	Accounting		\$ 20,755	Out-of-State Travel							
Care Centers Inc.	Accounting		13,750								
Care Centers Inc.	Data Processing		7,194								
ADP Inc.	Payroll		11,202	In-State Travel							
Personnel Planners	Unemployment Consultant		2,984								
Care Centers Inc.	Professional Fees		5,400								
BDO Seidman	Accounting - Line of Credit		1,230								
Legat Architects	Architects		2,492								
SMS	Medicare Billing Consult		8,465	Seminar Expense							
Joseph Abramchik	Acct Receivable Consultant		1,333	Educational Expense							
Morton Cohen	Pharmacy Cost Mgmt Cons.		6,846	Allocated from Care Centers							
See Supplemental Schedule			313,526								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 395,177	TOTAL		\$	6,023				

* Attach copy of IMRF notifications
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****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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<p>Facility Name & ID Number <u>International Village</u></p> <p>XX. GENERAL INFORMATION:</p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>Yes</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u> If YES, give association name and amount. <u>ICLTC \$5467</u></p> <p>(3) Did the nursing home make political contributions or payments to a political organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>10 yrs</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>1,589</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation. _____</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. _____</p> <p>(9) Are you presently operating under a sublease agreement? _____ YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ <u>119,682</u> This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation. _____</p>	<p style="text-align: center;">STATE OF ILLINOIS</p> <p># <u>0041590</u> Report Period Beginning: <u>01/01/04</u> Ending: <u>12/31/04</u> Page 23</p> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? <u>Yes</u></p> <p>(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>No</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ _____ Has any meal income been offset against related costs? <u>N/A</u> Indicate the amount. \$ _____</p> <p>(16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____ c. What percent of all travel expense relates to transportation of nurses and patients? <u>100% in 14</u> d. Have vehicle usage logs been maintained? <u>N/A</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u> g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____</p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____</p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees.</p>
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